GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue
Glenview, IL 60025

NAIC COMPANY CODE 64211
NAIC GROUP CODE 687

MARKET CONDUCT DESK EXAMINATION REPORT

as of
December 31, 2007

PREPARED BY
AN INDEPENDENT CONTRACT EXAMINER
AND
DIVISION EMPLOYEES
FOR THE
STATE OF COLORADO
DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

CERTIFICATE OF COPY

I, **Marcy Morrison**, Commissioner of Insurance of the State of Colorado, do hereby certify that the attached is a true and correct copy of the Market Conduct Examination Report as of December 31, 2007 for **Guarantee Trust Life Insurance Company** now on file as a record of this office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal of office at the City and County of Denver on this 4th day of December 2008.

Marcy Morrison
Commissioner of Insurance

GUARANTEE TRUST LIFE INSURANCE COMPANY

MARKET CONDUCT DESK
EXAMINATION REPORT

as of
December 31, 2007

Examination Performed by

Kathleen M. Bergan, CIE

An Independent Contract Examiner

and

Division of Insurance Staff

September 16, 2008

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway Suite 850
Denver, Colorado 80202

Commissioner Morrison:

In accordance with §§ 10-1-203, 10-1-210 and 10-3-1106, C.R.S., a market conduct desk examination of certain health insurance business practices of Guarantee Trust Life Insurance Company has been conducted.

The Company's policy forms, claims and underwriting records were examined by an independent contract examiner in South Bend, Indiana. The Company's premium and rating records were examined by Division staff at the Colorado Division of Insurance office in Denver, Colorado.

The examination of the forms, claims, and underwriting records covered the period from January 1, 2006 to December 31, 2006. The examination of the premium and rating records covered the period from January 1, 2006 to December 31, 2007.

A report of the desk examination of Guarantee Trust Life Insurance Company is herewith respectfully submitted.

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Kathleen M. Bergan, CIE

Independent Market Conduct Examiner

MARKET CONDUCT
DESK EXAMINATION REPORT
OF
GUARANTEE TRUST LIFE INSURANCE COMPANY

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COMPANY PROFILE

Guarantee Trust Life Insurance Company (GTLIC) hereinafter referred to as "the Company" is a mutual legal reserve life and health insurance company. The Company was incorporated under the laws of the State of Illinois on May 16, 1936 by the R.S. Holson family and commenced business on June 16, 1936.

The Company is licensed in forty-nine (49) states, the District of Columbia and Puerto Rico. The Company received a Certificate of Authority to conduct life and health business in Colorado on October 16, 1985. The Company sells a variety of life and health products through independent producers.

Effective January 2006, the Company entered into an Assumption Reinsurance Agreement with Empire Fire and Marine Insurance to acquire a block of health insurance business. This business was administered by American Select Insurance Management Corporation (ASIMC) which was responsible for the administrative duties of Empire Fire and Marine. Management duties of ASIMC as Program Manager include policy, form and rate filings as well as all other program compliance reporting to regulatory agencies including the Department of Insurance in the various states in which the business was sold. The Company received approval from the Illinois Department of Financial and Professional Regulation - Division of Insurance, and formally assumed this business in September of 2006. The Company has not transferred this block of health business to its own policy forms and has decided to keep it separate until all policies are terminated. A review of this reinsurance agreement was not performed; however, the Company did furnish a copy of an affidavit executed by the president of ASIMC, which states in part:

> "The Assumption Reinsurance Agreement, effective January 1, 2006, between the transferring insurer, Empire Fire and Marine Insurance Company ("Empire"), domiciled in Nebraska, and the assuming insurer, Guarantee Trust Life Insurance Company ("GTL"), domiciled in Illinois, does not involve any transfer of assets, liabilities or reserves with respect to the transaction. Accordingly, there is no change in the balance sheet of both the transferring insurer (Empire) and the assuming insurer (GTL), both prior to and after the transaction. Furthermore, no consideration is being paid or received by any person or entity with respect to this transaction."

An Assumption Notice was sent to Empire Fire and Marine policyholders informing them of the transfer of their policies to the Company.

The transaction was effective January 1, 2006, but all regulatory procedures or approvals by the Nebraska and Illinois Insurance Departments were not completed until September of 2006.

The Company utilized two Third Party Administrators (TPA's) for administration of the Colorado business. The two TPA's were Insurers Administrative Corporation (IAC) located in Phoenix, Arizona and Allied National Companies of Kansas City, Missouri.

PURPOSE AND SCOPE

This market conduct desk examination was performed by an independent contract examiner, who was assisted by Division of Insurance (Division) staff. This procedure is in accordance with Colorado insurance laws §§ 10-1-204 and 10-1-210, C.R.S., which empower the Commissioner to supplement the Division's resources to conduct market conduct examinations, and to determine the most appropriate action to be taken. The information in this report, including all work products developed in producing it, is the sole property of the Division.

The purpose of this desk examination was to determine the Company's compliance with Colorado insurance laws related to the following areas:

- Review of the Company's managed care access plans, and managed care provider directories to determine if adequate provider networks are maintained in all areas where the Company markets managed care plans.
- Review of the Company's underwriting procedures and overall handling of individual health insurance policies that are issued with exclusionary riders.
- Review of policy forms as related to policy exclusions.
- Review of the Company's claim handling from contracted providers in which one or more of the charges were determined to be ineligible under the plan, and which resulted in member responsibility for the ineligible charge(s).
- Review of the Company's provider contracts to determine compliance with the requirements of Colorado insurance laws pertaining to managed care plans.
- Review of the Company's premium and rating practices for individual health plans.

Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

This market conduct desk examination was conducted in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners (NAIC). In reviewing material for this report the examiners relied primarily on records and material maintained and/or submitted by the Company. The examination covered a twelve (12) month period of the Company's operations, from January 1, 2006 to December 31, 2006 for the Company's claims, forms, and underwriting records, and a twenty-four (24) month period from January 1, 2006 to December 31, 2007, for the Company's premium and rating records. The examination time period was expanded to twenty-four (24) months for premium and rating in order to review the handling of the block of business acquired from Empire Fire and Marine Insurance Company during calendar year 2006, as well as the Company's own new business during calendar years 2006 and 2007.

File sampling was based on a review of underwriting and claims files that were systematically selected using ACL™ software from computer data files provided by the company. Sample sizes were chosen based on guidelines developed by the NAIC. Upon review of each file, any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action. The examination report is a report by exception. Therefore, much of the material reviewed is not addressed in this report. Reference to any practices, procedures, or files which manifested no improprieties was omitted.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other system, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

Certain unacceptable or non-complying practices may not have been discovered in the course of the examination. Failure to identify or criticize specific Company practices does not constitute acceptance or endorsement by the Division. Examination findings may result in administrative action by the Division.

EXAMINATION METHODOLOGY

The examination consisted of a review of the Company's business practices to determine compliance with Colorado insurance laws. For this desk examination, special emphasis was given to the laws shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions.
Section 10-16-105.5, C.R.S.	Individual health plans – federally eligible individual – limited guarantee issue.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-108.5, C.R.S.	Fair marketing standards.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201, C.R.S.	Form and content of individual sickness and accident insurance policies.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-203, C.R.S.	Optional provisions in individual sickness and accident insurance policies.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration - repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act"
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-6	Concerning The Definition of The Term "Complications of Pregnancy" For Use In Accident And Health Insurance Policies
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One
Insurance Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
Insurance Regulation 4-6-5	Concerning The Basic and Standard Health Benefit Plans

Company Operations and Management

The examination included a review of Company management and quality controls, record retention, and timely cooperation with the examination process. In addition, the Company's managed care networks were reviewed to determine adequacy of providers.

Contract Forms

A review was performed of the following contract forms, endorsements and riders:

Form Number	Form Name
GTLIC	
I20031	Short Term Individual
GC-1200, Plan Code 848 ACC09	Blanket Accident Coverage
G0591-CO	Individual Health Insurance Policy/Major Medical Coverage.
IRG05IPRG	Initial Premium Rate Rider
RA06-23	Amendment Rider-Health Insurance Exclusions
RA05-15	Amendment Rider-Coverage for artificial limbs, etc.
NOT-05-CO REP	Notice of Replacement of Accident and Sickness Insurance
NOT-05-CO	Notice of Understanding
NOT-05-CO-DET	Determination of Self-Employed Business Group of One Form.
IRG05EER	Exclusion Endorsement by name
GTLPN-1	Privacy Notice
PN-2-1	Notice of Health Privacy Practices
GTL	Notice of Women's Health and Cancer Rights Act
IRG05OC	24 Hour Occupational Coverage Benefit Rider
RA05-13	Amendment Rider-Effective Date of Policy
IRG05PDC-CO	Prescription Drug Benefit Rider
IRG05RE	Rescission Endorsement
IRG05EER	Exclusion Endorsement
IRG05AMEB	Accident Medical Expense Benefit Rider
EMPIRE FIRE AND MARINE INS. CO.	
EM 28 22 (04-01)-P-CO	Individual Health Insurance Policy Major Medical Expense Coverage
EM 28-22 (04-01)-PRG-CO	Pregnancy Benefit Rider
EN 28-21 (04-01) SAB	Supplemental Accident Rider
EM 28-24 (04-01)-PDC	Prescription Drug Card Benefit Rider
EM 28 26 (04-01)-IPG	Premium Rate Rider
EM 28-27 (04-01)-AMD	Amendment Rider (Blank)
EM 28 28 (04-01)-EXC	Exclusion Endorsement Rider
EM 28 76 (04-01)-RID-CO	Policy Amendment Rider
EM 28-78 (10-03)-OCC	Occupational Coverage Amendment Rider
EM 28 26 (10-03)-IPG	Initial Premium Rate Guarantee Rider
EM 28 79 (02-04)-PPO-CO	Policy Amendment Rider
EM 28 83 (03-04)-IND-HDHP	Policy Amendment Rider
EM 28 84 (03-04)-IND-RPE	Policy Amendment Rider
EM 28 92 (12-05)-SR-CO	Policy Amendment Rider

Underwriting and Rating

For the period under examination, systematically selected samples (using a random seed) of underwriting files with exclusionary riders was taken as follows:

Policies with Exclusionary Riders
January 1, 2006 through December 31, 2006

Review Lists	Population	Sample Size	Percentage of Population
Policies with Exclusionary Riders	1,323	50	3.78

Underwriting files which contained exclusionary riders were reviewed to trace actual documentation to the reason for the exclusion.

No underwriting review was performed on the health policies assumed by the Company from Empire Fire and Marine Insurance Company as no new business was written during the period under examination.

During the examination, the scope was expanded to include a review of the Company's rating practices related to individual health plan business in Colorado. This portion of the examination was conducted by Division staff. The following random samples of individual health policies sold during 2006 and 2007 were reviewed:

- Fifty (50) individual health policies from a population of 453 policies covering Colorado members from the block of business acquired from Empire Fire & Marine Insurance Company during calendar year 2006 (form number EM 28 18(04-01)-P-CO).

- Fifty (50) individual health policies from a population of 2,254 policies covering Colorado members issued or renewed by Guarantee Trust Life Insurance Company during calendar years 2006 and 2007 (form number G0591-CO).

Claims

The following shows the claim population to sample size for the period under review:

Denied Claims
January 1, 2006 through December 31, 2006

Review Lists	Population	Sample Size	Percentage of Population
Denied claims	2,330	50	2.15%

A combined sample of denied claims for both GTLIC and the assumed business of Empire Fire and Marine Insurance Company was randomly selected for the period under review. This review centered on claims denied due to ineligible coverage for benefits, which resulted in the member responsibility for the ineligible charge(s).

EXAMINATION REPORT SUMMARY

The examination resulted in a total of six (6) findings in which the Company did not appear to be in compliance with Colorado insurance laws. The following is a summary of the examiner's findings.

Company Operations and Management:

In the area of company operations and management one (1) compliance issue is addressed in this report involving the Company's managed care access plans, provider directories and provider network adequacy in areas in which it markets a managed health care plan.

Issue A1: Failure, in some cases, to maintain an adequate and complete network of providers.

Contract Forms:

In the area of contract forms, two (2) compliance issues are addressed in this report:

Issue E1: Failure to allow benefits for covered services based on a licensed provider's status (e.g., employed or retained by the policyholder, or a member of the insured's family).

Issue E2: Failure, in some cases, to include coverage for treatment needed as a result of an insured's participation in the activity of skiing.

Underwriting and Rating:

In the area of underwriting and rating, three (3) compliance issues are addressed in this report:

Issue G1: Failure, in some cases, to issue health insurance policies with exclusionary riders that comply with Colorado insurance law.

Issue G2: Failure, in some cases, to file rates for individual medical plans.

Issue G3: Failure, in some cases, to charge filed rates for individual medical plans.

A copy of the Company's response, if applicable, can be obtained by contacting the Company. Results of any previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

GUARANTEE TRUST LIFE INSURANCE COMPANY

FACTUAL FINDINGS

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure, in some cases, to maintain an adequate and complete network of providers.

Section 10-16-704, C.R.S., Network adequacy - rules - legislative declaration - repeal, states in part:

(1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

(a) Provider-covered person ratios by specialty, which may include the use of providers through telemedicine for services that may appropriately be provided through telemedicine;

(b) Primary care provider-covered person ratios;

(c) Geographic accessibility, which in some circumstances may require the crossing of county or state lines;

(d) Waiting times for appointments with participating providers;

(e) Hours of operation;

(f) The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care; and

(g) An adequate number of accessible acute care hospital services within a reasonable distance, travel time, or both.

(2) (a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

(6) The carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to covered persons and shall only market a network plan in a geographic area where network providers are accessible without unreasonable delay. In determining whether a health carrier has complied with this subsection (6), consideration shall be given to the relative availability of health care providers in the service area under consideration.

(9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a managed care plan shall demonstrate the following:

(a) An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

(a.3) An adequate number of accessible primary care providers within a reasonable distance or travel time, or both;

(a.5) An adequate number of accessible specialists and sub-specialists within a reasonable distance or travel time, or both, or who may be available through the use of telemedicine;

(a.7) Geographic accessibility, which in some circumstances may require the crossing of county or state lines;

(a.9) If the covered person has a pharmacy benefit, an adequate number of pharmacy providers within a reasonable distance, travel time, delivery time, or all three. Nothing in this paragraph (a.9) shall preclude the use of a retail or mail-order pharmacy provider.

(b) A carrier offering a managed care plan shall maintain procedures for making referrals within and outside its network that, at a minimum, must include the following:

(I) A comprehensive listing, made available to covered persons and primary care providers, of the plan's network participating providers and facilities;

(II)(A) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a health maintenance organization may offer variable deductibles and copayments to encourage the selection of certain providers.

During the course of the examination repeated attempts were made by the examiner to obtain a list of providers by specialty for one of the Company's managed care networks, (Private Health Care Systems, herein after referred to as "PHCS"). In response to these requests, a list of PHCS providers was provided; however, no specialty other than "PROF" was listed in the field for provider type code. Therefore, no discernable determination could be made of network adequacy by provider specialty.

The Company did ultimately provide a listing of participating providers by address, city and county. This information was sorted by county to determine the number of providers in each area.

In reviewing the number of physicians (without the requested specialty data) the examiner determined that some counties had as few as one (1) contracted provider. The following list provides examples of the counties that do not appear to contain a sufficient number of providers to represent an adequate provider network:

Number of Providers	County
4	Clear Creek
2	Costilla
1	Custer
1	Crowley
5	Kiowa
18	Las Animas
6	Pitkin
12	Moffat
5	Bent

Based on the review of the contracted provider data provided by the Company, it did not appear that there were sufficient numbers of contracted providers in all areas, even though the examiner could not determine adequacy by specialty due to the incomplete data provided. In addition, the Company reportedly agreed in a response to a consumer complaint that the PHCS network did not include providers for some needed services in some areas of Colorado. Therefore, it does not appear that the Company maintained a network that was sufficient in numbers and types of providers to assure that all covered benefits were accessible to covered persons without unreasonable delay in all areas where this managed care plan was offered, as required by Colorado insurance law.

Recommendation Number 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has implemented necessary changes in order to ensure that it maintains an adequate network of providers in each area of Colorado where its managed care products are marketed, as required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure to allow benefits for covered services based on a licensed provider's status (e.g., employed or retained by the policyholder, or a member of the insured's family).

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of Part 2 of this article or a prepaid dental care plan subject to the provisions of Part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.

It appears that the Company is not in compliance with Colorado insurance law in that its Blanket Accident Policy excludes coverage for treatment from providers who are employed or retained by the policyholder, or from any family member.

The Company's form (GC-1200 ACC09 Plan Code 848, page 9) states under Exclusions:

This Certificate does not include benefits for:

Treatment, services or supplies which:

Are received from persons employed or retained by the policyholder or any family member, unless otherwise specified. [Emphasis added].

This exclusion does not appear to be in compliance with Colorado insurance law because the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider is practicing within the scope of his or her license, and normally charges for the services, regardless of whether the provider may be an employee or a member of the insured's family.

Recommendation Number 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable forms to provide coverage for licensed providers who are providing covered services within the scope of their license, as required by Colorado insurance law. The Company should also be required to conduct a self-audit and adjust any claims that were denied due to the above policy exclusion.

Issue E2: Failure, in some cases, to include coverage for treatment needed as a result of an insured's participation in the activity of skiing.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive or practices states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of the part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(XVI) Excluding medical benefits under health care coverage subject to article 16 of this title to any covered individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off highway vehicle riding; *skiing*; or snowboarding. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its Blanket Accident Coverage policy form (GC-1200 (Page 9)) excludes coverage for any injury sustained skiing.

The Company's form states:

This certificate does not provide benefits for:

- Injury sustained skiing or participating in a rodeo.

Recommendation Number 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable forms to allow coverage for skiing and other casual or nonprofessional sporting activities as required by Colorado insurance law. The Company should also be required to conduct a self-audit and adjust any claims that were denied due to the above policy exclusion.

UNDERWRITING AND RATING

Issue G1: Failure, in some cases, to issue health insurance policies with exclusionary riders that comply with Colorado insurance law.

.
Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (f)(XI) Reducing benefits under a health insurance policy by the addition of an exclusionary rider, unless such rider only excludes conditions which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition;

During the review of underwriting and policy files issued with exclusionary riders, it was noted that the Company issued policies with exclusionary riders that were too general or broad for the specific condition documented on the original underwriting application or subsequent medical records provided to underwrite the policy. Colorado insurance law requires exclusionary riders to be limited to the specific condition(s) that have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition. In addition, Colorado insurance law does not allow for the exclusion of specific procedures or body parts.

The following chart illustrates the significance of error versus that population and sample examined:

Policies with Exclusionary Riders
January 1, 2006 through December 31, 2006

Review Lists	Population	Sample Size	Number of Exceptions	Percentage to Sample
Policies with Exclusionary Riders	1,323	50	4	8%

An examination of fifty (50) individual policies that were issued with an exclusionary rider, resulted in four (4) exceptions (8% of the sample) wherein the rider excluded either a specific procedure or body part, or the description of the condition that was excluded was too broad or general with regard to the condition(s) that had been disclosed during the underwriting process.

Recommendation Number 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to provide such proof, it should provide evidence to the Division that it has amended its procedures to ensure that all exclusionary riders are limited to conditions which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition, as required by Colorado insurance law. The Company should also be required to conduct a self-audit and adjust any claims that were denied due to exclusionary riders that were not in compliance with Colorado insurance law.

Issue G2: Failure, in some cases, to file rates for individual medical plans.

Section 10-16-107, C.R.S., Rate regulation - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees - disclosures on treatment of intractable pain, states in part:

> (2) *No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state,* nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 *and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.* [Emphases added.]

Colorado Insurance Regulation 4-2-11, Rate Filing and Annual Report Submissions Health Insurance, states in part:

Section 4 Definitions

> M. "Rate Filing" means, for purposes of this regulation, is a filing that contains all of the items required in this regulation and the bulletin entitled “Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers”, and 1) for individual products, the proposed base rates and all rating factors, the underlying rating assumptions; and 2) for group products, the underlying rating factors and assumptions, and support for changes in these factors and assumptions.

Section 5 General Rate filing Requirements

> A. General Requirements
>
> 1. Required Submissions:
>
> a. *All companies must submit rate filings whenever the rates charged new or renewal policy holders or certificateholders differ from the rates on file with the Division of Insurance.* Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or changes(s) in the trend or other rating assumptions. A company may file changes to the base rates or the index rate, for small group rate filings, due solely to trend for a maximum of one year. The continued use of a trend or any other continuing assumption is required to be verified at least annually for continued appropriateness.
>
> 2. Time and Submission: Unless a filing is specifically identified as requiring prior approval (e.g. Medicare Supplemental), all filings are classified as “file and use.” *“File and use” requires the company to file the rates and rating data with the Division of Insurance concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates* except as provided for in Section 7(C) of this regulation for large

> group contracts. If a rate change has been implemented without being filed with the Division of Insurance, corrective actions may be ordered, including fines, refunds to policyholders, and/or rate credits. All filings must be filed with the Rates and Forms Section of the Division of Insurance. [Emphases added.]

The following chart illustrates the significance of error versus that population and sample examined:

Individual Health Policies Acquired From Empire Fire & Marine IC
January 1, 2006 through December 31, 2006

Population	Sample Size	Number of Exceptions	Percentage to Sample
453	50	50	100%

It appears that the Company is not in compliance with Colorado insurance law in that it failed to file rates for either 2006 or 2007 for the block of individual health insurance business taken over from Empire Fire & Marine Insurance Company (form number EM 28 18(04-01)-P-CO). Using any rate not specifically filed for use in Colorado is a violation of Colorado insurance law.

Recommendation Number 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11. In the event the Company is unable to provide such proof, it should provide evidence to the Division that it has amended its procedures to ensure that rates are filed for all health insurance products marketed in Colorado, as required by Colorado insurance law.

Issue G3: Failure, in some cases, to charge filed rates for individual medical plans.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(f)(II) Unfair discrimination: *Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance*, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever; [Emphasis added.]

Section 10-16-107, C.R.S., Rate regulation - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees - disclosures on treatment of intractable pain, states in part:

(2) *No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state*, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 *and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.* [Emphases added.]

Colorado Insurance Regulation 4-2-11, Rate Filing and Annual Report Submissions Health Insurance, states in part:

Section 4 Definitions

M. "Rate Filing" means, for purposes of this regulation, is a filing that contains all of the items required in this regulation and the bulletin entitled “Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers”, and 1) for individual products, the proposed base rates and all rating factors, the underlying rating assumptions; and 2) for group products, the underlying rating factors and assumptions, and support for changes in these factors and assumptions.

Section 5 General Rate filing Requirements

A. General Requirements

1. Required Submissions:

a. *All companies must submit rate filings whenever the rates charged new or renewal policy holders or certificateholders differ from the rates on file with the Division of Insurance.* Included in this requirement are

changes due to periodic recalculation of experience, change in rate calculation methodology, or changes(s) in the trend or other rating assumptions. A company may file changes to the base rates or the index rate, for small group rate filings, due solely to trend for a maximum of one year. The continued use of a trend or any other continuing assumption is required to be verified at least annually for continued appropriateness.

2. Time and Submission: Unless a filing is specifically identified as requiring prior approval (e.g. Medicare Supplemental), all filings are classified as "file and use." *"File and use" requires the company to file the rates and rating data with the Division of Insurance concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates* except as provided for in Section 7(C) of this regulation for large group contracts. If a rate change has been implemented without being filed with the Division of Insurance, correction actions may be ordered, including fines, refunds to policyholders, and/or rate credits. All filings must be filed with the Rates and Forms Section of the Division of Insurance. [Emphases added.]

The following chart illustrates the significance of error versus that population and sample examined:

Individual Health Policies Issues by GTLIC
January 1, 2006 through December 31, 2007

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,254	50	30	60%

It appears that the Company is not in compliance with Colorado insurance law in that in thirty (30) out of the fifty (50) files tested, the rates charged on new individual accident and health policies (form number G0591-CO) did not match the rates filed with the Division. Using rates that differ from filed rates is a form of unfair discrimination in that individuals with similar rating characteristics and/or similar expenses are not charged similar rates.

Recommendation Number 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, & 10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11. In the event the Company is unable to provide such proof, it should provide evidence to the Division that it has amended its procedures to ensure that rates charged for all health insurance products marketed in Colorado match the rates filed with the Division for those products, as required by Colorado insurance law. The Company should also be required to conduct a self-audit of the premium calculations for all individual policies issued from January 1, 2007 to the present, and refund any overcharges that resulted from the failure to charge the filed rates.

Summary of Issues and Recommendations

GUARANTEE TRUST LIFE INSURANCE COMPANY

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